FIELD INDICATOR KEYS

ANESTHESIA SECTION

Column Title	Title Explanation	Indicator	Indicator Description
ANES CODE	Anesthesia Code		*2001 CPT* or *ASARVG* code
ABBREVIATED DESCRIPTION			Descriptions are abbreviated and are for reference purposes only. For complete descriptions, refer to a *2001 CPT* or *ASARVG*.
ANES BASE	Anesthesia Base Units	Number or coverage status	A number indicates the anesthesia base units assigned to the procedure. Not Covered and By Report codes are also indicated in this column.
MAX FEE	Maximum fee	Dollar value	Indicates the maximum fee for anesthesia codes not priced with anesthesia base units.
CODE SOURCE			Indicates source of code, *2001 CPT* or *ASARVG*. Blanks indicate *2001 CPT* is the code source.

ALL OTHER SECTIONS

Column Title	Title Explanation	Indicator	Indicator Description
CPT/HCPCS CODE			*2001 CPT* or HCPCS code
ABBREVIATED DESCRIPTION			Descriptions are abbreviated and are for reference purposes only. For complete descriptions, refer to a *2001 CPT* or HCPCS book.
NON-FACILITY SETTING DOLLAR VALUE		Dollar value or coverage status	The maximum dollar amount the department will pay for covered services provided in a non-facility setting. Average Wholesale Price (AWP), Bundled, By Report, Contracted, Info Only, and Not Covered codes are also indicated here. Average wholesale prices are posted on website http://www.lni.wa.gov/hsa/payment.htm or contact provider hotline at 1-800-848-0811.
FACILITY SETTING DOLLAR VALUE		Dollar value or coverage status	The maximum dollar amount the department will pay for covered services provided in a facility setting. Average Wholesale Price (AWP), Bundled, By Report, Contracted, Info Only, and Not Covered codes are also indicated here. Average wholesale prices are posted on website http://www.lni.wa.gov/hsa/payment.htm or contact provider hotline at 1-800-848-0811.
FOL UP	Follow-up	Follow-up days for global surgery	Number of days following surgery during which charges for normal postoperative care are bundled in the global surgery fee.

Column Title	Title Explanation	Indicator	Indicator Description
PRE OP	Preoperative Percentage (Modifier -56)	Percentage	Percent of total global surgery dollar value allowed when modifier -56 (Preoperative Management) is billed.
INTRA OP	Intraoperative Percentage (Modifier -54)	Percentage	Percent of total global surgery dollar value allowed when modifier -54 (Surgical Care) is billed.
POST OP	Postoperative Percentage (Modifier -55)	Percentage	Percent of total global surgery dollar value allowed when modifier -55 (Postoperative Management) is billed.
PCTC	Professional and Technical Component (Modifiers -26/-TC)	Number	**This field identifies procedure codes which can be split into professional and technical components. Valid values for these field indicators include:**
		0	Physician services only. The concept of PC/TC does not apply. Modifiers **-26 and -TC are not valid for this procedure.**
		1	Diagnostic test or radiology service which has both a professional and technical component. **Modifiers -26 and -TC are valid for this procedure.**
		2	Stand alone code that describes the professional component of a diagnostic test for which there is: a) an associated code that describes the technical component of the diagnostic test only and b) another associated code that describes the global procedure (the professional and technical components). **Modifiers -26 and -TC are not valid for this procedure.**
		3	Stand alone code that describes the technical component of a diagnostic test for which there is: a) an associated code that describes the professional component of the diagnostic test only and b) another associated code that describes the global procedure (the professional and technical components). **Modifiers -26 and -TC are not valid for this procedure.**
		4	Stand alone code that describes the global procedure for a diagnostic test for which there are associated codes that describe: a) the professional component of the test only, and b) the technical component of the test only. **Modifiers -26 and -TC are not valid for this procedure.**
		5	Covered service that is incident to a physician's service when provided by auxiliary personnel employed by the physician and working under his/her direct personal supervision. Payment may not be made for this service when provided to hospital inpatients or outpatients. **Modifiers -26 and -TC are not valid for this procedure.**

Column Title	Title Explanation	Indicator	Indicator Description
PCTC (continued)		**6**	Clinical laboratory or other service for which separate payment for interpretations by laboratory physicians or other physicians may be made. **Modifier -TC is not valid for this procedure. Modifier -26 may be valid for this procedure**.
		7	This indicator is not currently in use.
		8	Professional component of a clinical laboratory code for which separate payment may be made *only* if the physician interprets an abnormal smear for a hospital inpatient. **No -TC modifier billing is recognized** because payment for the underlying clinical laboratory test is made to the hospital**. No payment is recognized for these codes when furnished to hospital outpatients or non-hospital patients.**
		9	Concept of a professional/technical component split does not apply. **Modifiers -26 and -TC are not valid for this procedure.**
MSI	Multiple Surgery Indicator (Modifier -51)	Number	**This field indicates the multiple surgery payment rules that apply to the service. Multiple procedures are identified by modifier -51. Valid values for this field include:**
		0	Payment adjustment rules for multiple surgery do not apply. **Modifier -51 is not valid for this procedure.**
		1	This indicator is not currently in use.
		2	Standard multiple surgery payment policy applies (100%, 50%, 50%, 50%, 50%). **Modifier -51 is valid for this procedure.**
		3	Multiple endoscopic procedures payment policy applies if this service is billed with another endoscopy in the same family. **Modifier -51 may be valid for this procedure.**
		4	This indicator is not currently in use.
		9	Concept of multiple surgery does not apply. **Modifier -51 is not valid for this procedure.**
BSI	Bilateral Surgery Indicator (Modifier -50)	Number	**This field indicates that the procedure is subject to a payment adjustment for bilateral surgery. Bilateral procedures are identified by modifier -50. Valid values for this field include:**
		0	Payment adjustment rule for bilateral surgery does not apply. **Modifier -50 is not valid for this procedure.**
		1	Payment adjustment for bilateral procedures (150%) applies to this procedure. **Modifier -50 is valid for this procedure.**

Column Title	Title Explanation	Indicator	Indicator Description
BSI (continued)		**2**	Payment adjustment for bilateral procedures does not apply. Procedures in this category include services for which the code descriptor specifically states that the procedure is bilateral; procedures that are usually performed as bilateral procedures; or procedures for which the code descriptor indicates the procedures may be performed either unilaterally or bilaterally. **Modifier -50 is not valid for this procedure.**
		3	Payment adjustment for bilateral procedure does not apply. This is a radiology procedure which is not subject to payment rules for bilateral surgeries. **Modifier -50 is not valid for this procedure**.
		9	Concept of bilateral surgery does not apply. **Modifier -50 is not valid for this procedure.**
ASI	Assistant Surgeon Indicator (Modifier -80)	Number	**This field indicates whether or not an assistant surgeon may be paid for the procedure. Assistants at surgery are indicated by modifiers -80, -81 and -82. Valid values for this field include:**
		0	Assistant at surgery is not usually paid for this procedure. Supporting documentation is necessary to establish medical necessity. **Modifiers -80, -81 and -82 are not valid under normal situations for this service.**
		1	Assistant at surgery may not be paid for this procedure. **Modifiers -80, -81 and -82 are not valid for this service.**
		2	Assistant at surgery may be paid. **Modifiers -80, -81 and -82 are valid for this service.**
		9	Concept does not apply. **Modifiers -80, -81 and -82 are not valid for this service.**
CSI	Co-surgeons Indicator (Modifier -62)	Number	**Indicates whether or not two surgeons, each in a different specialty, may be paid for the procedure. Co-surgeons are indicated by modifier -62. Valid values for this field include:**
		0	Co-surgeons not permitted. **Modifier -62 is not valid with this procedure**.
		1	Co-surgeons may be paid for this procedure. Supporting documentation is required to establish medical necessity of two surgeons. **Modifier -62 is not valid under normal situations for this procedure.**
		2	Co-surgeons may be paid for this procedure. No supporting documentation is required if two specialty requirement is met. **Modifier -62 is valid with this procedure.**
		9	Concept of co-surgeons does not apply. **Modifier -62 is not valid with this procedure.**

Column Title	Title Explanation	Indicator	Indicator Description
TSI	Team Surgeons Indicator (Modifier -66)	Number	**Indicates whether or not team surgeons may be paid for the procedure. Team surgeons are indicated by modifier -66. Valid values for this field include:**
		0	Team surgeons not permitted. **Modifier -66 is not valid with this procedure.**
		1	Team surgeons may be payable. Supporting documentation is required to establish medical necessity of a team. **Modifier -66 is not valid under normal situations for this procedure.**
		2	Team surgeons permitted. **Modifier -66 is valid with this procedure.**
		9	Concept of team surgery does not apply. **Modifier -66 is not valid with this procedure.**
ENDO BASE	Endoscopy Base Code	Code number	**This column contains the endoscopic base code of which the CPT code listed in the first column is a family member. The Multiple Surgery Indicator is 3.**
FSI	Fee Schedule Indicator	Letter	**This column indicates the type of payment status. Valid values for this field include:**
		B	Bundled code, not separately payable
		C	Contracted service. Payable only to department's contracted vendor for State Fund claims. Payable to providers treating Self-Insured injured workers.
		D	Drug fee based on Average Wholesale Price (AWP)
		F	Flat fee developed by the department
		L	Clinical lab fee
		N	No fee or RVUs available, code paid By Report
		O	Informational only. Used for outpatient prospective payment system.
		R	RBRVS fee
		X	Non-covered code